

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014	
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BLOOMINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403			
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F000000	<p>This visit was a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00156243.</p> <p>Survey dates: September 10, 11, 12, 15, and 16, 2014.</p> <p>Facility number: 000007 Provider number: 155019 AIM number: 100275040</p> <p>Survey Team: Melissa Gillis, RN-TC Cheryl Mabry, RN Shelly Miller-Vice, RN Angie Patterson, RN (9/11, 9/12, 9/15)</p> <p>Census bed type: SNF: 10 SNF/NF: 172 Total: 182</p> <p>Census payor type: Medicare: 13 Medicaid: 137 Other: 32 Total: 182</p>			F000000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000223 SS=A	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 24, 2014; by Kimberly Perigo, RN.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from physical abuse in that a facility staff hit a resident on the arm. (Resident #7) (Certified Nursing Assistant (CNA))</p>		F000223	<p>It is with complete dedication that we rectify these cited areas. We strive daily to provide an environment that is safe and care is provided in a loving caring way. We respectfully submit this plan of correction as proof of our compliance with State and</p>		10/13/2014	

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	<p>#4)</p> <p>Findings include:</p> <p>The clinical record for Resident #7 was reviewed on 9/16/14 at 10:00 a.m. Diagnoses included, but were not limited to, atherosclerotic heart disease, cerebral aneurysm rupture, congestive heart failure (CHF), dementia, diabetes, expressive aphasia, subarachnoid hemorrhage, and seizure activity.</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 8/14/14, indicated a BIMS (Brief Interview Mental Status) score as 0. Zero being cognitively impaired and dependent on nursing staff for daily decision making.</p> <p>Interview on 9/16/14 at 10:15 a.m., with Resident #7 indicated when asked if staff handled her roughly, "Yes." Resident was not able to be understood when asked what roughly meant, her speech was garbled (expressive aphasia). Resident #7 was only able to answer in yes or no responses. When asked if Resident #7 was fine now indicated, "Yes."</p> <p>Interview on 9/16/14 at 10:25 a.m., with CNA #3 (witness) indicated, "Me</p>			<p>Federal regulations, and per the laws that mandate the submission of this plan. We respectfully request a desk review/paper compliance for the plan of correction submitted. Please review the attached documents with this plan of correction, as evidence of completion of this plan of correction and evidence of compliance. F223 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #7 has been assessed with no injury or ill effect regarding this incident. Nursing and Social Services continues to monitor to ensure resident remains free from any abuse. CNA #4 was terminated. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by abuse. Inservice was given regarding abuse and reporting. All facility staff were required to read and sign the training provided. See attached #1. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Upon hire, criminal history checks and drug testing are done, dementia and abuse training is completed and at least annually</p>			

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	<p>and another lady" was helping Resident #7 to the bathroom. After we sat Resident #7 on the toilet, Resident #7 slapped CNA #4 and CNA #4 slapped the resident back on the arm and said, "I slap back." We stood Resident #7 up and she [Resident #7] was still struggling and CNA #4 took her bicep [upper arm] and pushed Resident #7 up against the wall and did this three times. We then got Resident #7 to bed.</p> <p>Review on 9/16/14 at 9:00 a.m., of "State Agency Unusual Occurrence Report" provided by the facility, indicated, "...Description of Incident: NA [Nursing Assistant / CNA #3], reported that during peri-care with [Resident #7], CNA [CNA #4], was too rough. Action taken: As soon as report was made CNA [CNA #4], was escorted out of facility. Resident was assessed for injuries, none found and resident denies being afraid or having been hurt. POA [Power of Attorney] and physician notified. Social services notified....it has been determined to terminate CNA [CNA #4] as [Resident #7] is not reliable as to time frames and staff names or faces and [CNA #3] and [CNA #4] stories do not match. 100% of resident's living on unit have been interviewed and denies being</p>		<p>thereafter. All staff have been educated on what abuse looks like and signs and symptoms of staff burnout. The process for shift report has changed to have licensed staff report information about resident change in condition to the CNAs and needed change in interventions in their care. This process will be a more proactive approach versus reactive. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; In addition to our current Quality Assurance program, daily, administrative staff will verify any changes in resident care interventions have been updated on CNA assignment sheets and Care Plans and communicated to floor staff. Monthly this report will be included in the QA program. After 3 months, this process will be reviewed for a scheule change if no concerns found. ADDENDUM: While Garden Villa has a Chain of Command, in this circumstance, we train staff to follow the guidelines set forth in the Elder Abuse Act stating : "Each employee, agent, contractor, manager, owner, or operator of this facility is individually responsible to report the reasonable suspicion of a crime against a resident.." The education was clarified to explain</p>				

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	<p>treated roughly."</p> <p>CNA #4's report, dated 9/12/14, indicated, "Concerning [Resident #7], I helped new employee [CNA #3] get her out of her recliner and into the bathroom to change for bed. [Resident #7] was combative as usual but no more than usual. [Resident #7] swatted at me, tried to pull new employee's hair. [Resident] had a b/m [bowel movement] and was not willing to allow aid to clean her. I took the position of someone who had worked with [Resident #7] and familiar with her behavior, and cleaned her bottom and put her legs up in bed and exited the room never to return the rest of the evening or following morning."</p> <p>CNA #3's report, no date, indicated, "Last night I saw a employee when [Resident #7] got mad and slapped employee on arm, she [CNA #4] slapped her back on the arm and said, 'I slap back.' Then when she [CNA #4] was cleaning her bottom, [Resident #7] started screaming and crying so she [CNA #4] kept shoving her [Resident #7] against the wall 3 times just to clean her."</p> <p>Administrator's report, dated 9/12/14, indicated "Received a report of rough</p>		<p>to the staff that suspicion is all they need to report and the investigation will be done to determine outcome. All allegations will be reported to the ISDH. This training includes all staff working all shifts. 5) By what date the systemic changes will be completed. October 13, 2014</p>				

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	care from [CNA #3] this am. She wrote that a co-worker [CNA #4] slapped and shoved [Resident #7] while providing care. I asked [CNA #3] to not only describe what happened but to demonstrate on me. She proceeded to have me sit in a chair as if it were a toilet, she [CNA #3] said the resident pulled her [CNA #3] hair and was slapping at them, striking [CNA #4]. CNA #4 then smacked her [Resident #7] back on the arm and said, 'I hit back.' [CNA #3] barely struck my arm and I said no hit me the way she [CNA #4] did the resident she [CNA 3#] said I did it wasn't hard. I said was it like when you are saying to a child no I'll smack and swap them. She said yes like that. So was it done to hurt me, she [CNA #3] said no...She [CNA #3] had me stand and pretend I was holding a walker and the hand rail on one side. [CNA #3] leaned against me as she pretended to wipe me from the back. She [CNA #3] said the resident was fighting and pushing against her. [CNA #4] said nothing but pushed her [Resident] forward 3 times to be able to complete the hygiene. I said was it harsh, she [CNA #3] said yes. I said could it have been to just pushing her forward to get her clean as she was fighting. She [CNA #3] said no it was different than the smack. [CNA #4]						

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	<p>was interviewed this am and gave a statement. She [CNA #4] indicated she only was providing care and was not abusive...[Resident #7] was assessed and talked too. She has no injuries and is unable to describe any incident...[CNA #4] and [CNA #3] are not reporting the same story... [CNA #4] was terminated to ensure safety of the resident..."</p> <p>On 9/10/14 at 11:00 a.m., the Administrator provided the Abuse Prevention Program, revised date 3/2004, and indicated the policy was the one currently being used by the facility. The policy indicated, "Policy Statement: Our residents have the right to be free from abuse, neglect...Policy Interpretation and Implementation 1. Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff,...2. Our facility conducts employee background checks and will not knowingly employ any individual who has been convicted of abusing, neglecting, or mistreating individuals...3. Our abuse prevention program provides policies...a. Protocols for conducting employment background checks. b. Mandated staff training/orientation programs that include such topics as abuse</p>						

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	<p>prevention, identification and reporting of abuse...c. Identification of occurrences and patterns of potential mistreatment/abuse...f. Timely and thorough investigations of all reports and allegations of abuse... These are different types of abuse: ... Catastrophic reactions-extraordinary reactions by a resident over ordinary stimuli, such as basic care. Response may be weeping, anger, agitation, ... Any complaints of abuse by a resident ... will be immediately addressed by the nurse on duty and a Concern/Suggestion form on behalf of the resident.... The staff will take immediate precautions to assure the resident is protected from any further abusive acts while the report is being investigated, such as staff suspension, separating residents or increased observation. Social service will visit the resident to assess for psychosocial needs. ... While these initial report forms need to be initiated by the staff nurse, the Administrator and Director of Nursing ... should be notified immediately and will begin the report to the State Board of Health, ...if no bodily injury has occurred the report will be sent within 24 hours, ...Abuse... Every resident has the right to be free from mistreatment, ...All reporting by staff to the RN on call and/or the administrator must occur immediately as the incident has occurred</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/20/2014
FORM APPROVED
OMB NO. 0938-0391

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	... the investigation must be immediately..." 3.1-27(a)(1)						
F000224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP RIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review,		F000224	F224 It is the policy of Garden		10/13/2014	

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	<p>the facility failed to ensure that each resident was free from mistreatment for 1 of 1 resident reviewed for abuse. (Resident #143, QMA #1, RN #3)</p> <p>Findings include:</p> <p>Resident #143's clinical record was reviewed on 9/12/14 at 1:43 p.m. Diagnoses included, but were not limited to: anxiety, depression with suicidal ideation, atrial fibrillation (irregular heart rhythm) hypertension, insomnia, and osteoarthritis.</p> <p>The current MDS (Minimum Data Set) assessment dated 7/30/14, indicated a BIMS (Brief Interview Mental Status) score was 13. When 8-15 indicated Resident #143 was cognitively intact and interviewable.</p> <p>On 9/11/14 at 8:59 a.m., interview with Resident #143 indicated when asked has staff, a resident or anyone else here abused you? "Yes, I don't know the name of the CNA [QMA #1], but she threw me against the wall while putting me in bed and being very rude. While rolling me over she pushed me real hard against the pins in my back. I hollered and she still pushed against the pins. I told the head of the station and they didn't fire her, but they moved her to the other</p>		<p>Villa to ensure that residents are free from mistreatment. Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements. 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The QMA in question no longer provides care for Resident #143, though Resident #143 has verbalized he welcomed the interaction and care from QMA #1. A careplan was held with Resident #143 and the POA. Both agree that they feel that Resident #143 is safe in our care and have no concerns about his well being beyond his cognitive impairment. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken All residents have the potential to be affected by abuse. Inservice was given regarding abuse and reporting. All facility staff were required to read and sign the training provided. See attached #1. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur Upon hire, criminal history checks and drug testing are done, dementia and abuse training is completed and at least annually thereafter. All staff have</p>				

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	<p>side. She don't take care of me anymore."</p> <p>On 9/15/14 at 8:54 a.m. interview with QMA #1 indicated, when asked if she could tell me about the incident with [Name of Resident #143], "I don't really remember, but I had never had any problems with him before that day. I just remember him getting a little upset with me. I don't know if he was just having a bad day that day. We've been fine since." When asked if she still provided care for Resident #143, QMA #1 indicated, "I still check on him when I work. There is no problem. He see's me in the hall and speaks. This was not my regular hall."</p> <p>On 9/12/14 2:49 p.m., interview with the Administrator indicated, An Allegation of abuse came up, [Name of Resident #143], with QMA #1. I can not tell you dates, one morning I walked down the hall, Resident #143 said, a CNA [QMA #1] bumped him into the wall. I immediately called the QMA #1. QMA #1 indicated, "The legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating RN #3]." When I asked [Name of Resident #143] if QMA #1 did it intentionally Resident #143 said, "She did not intentionally do it, she apologized to me." During continued interview Resident #143 he did not feel</p>		<p>been educated on what abuse looks like and signs and symptoms of staff burnout. The process for shift report has changed to have licensed staff report information about resident change in condition to the CNAs and needed change in interventions in their care. This process will be a more proactive approach versus reactive.</p> <p>4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>In addition to our current Quality Assurance program, daily, administrative staff will verify any changes in resident care interventions have been updated on CNA assignment sheets and Care Plans and communicated to floor staff. Monthly this report will be included in the QA program. After 3 months, this process will be reviewed for a scheule change if no concerns found. ADDENDUM: While Garden Villa has a Chain of Command, in this circumstance, we train staff to follow the guidelines set forth in the Elder Abuse Act stating : "Each employee, agent, contractor, manager, owner, or operator of this facility is individually responsible to report the reasonable suspicion of a crime against a resident.." The education was clarified to explain to the staff that suspicion is all</p>				

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	<p>like the CNA did it on purpose and it was an accident. I called the daughter and explained to her that he has repeated that again. [indicating speaking about the incident with QMA #1] he said that she put him on the bed. The nurse that watched said that it wasn't like that. Morning care was being provided, he was already in bed.</p> <p>On 9/15/14 at 9:32 a.m., interview with Resident #143 indicated when asked if he was okay with QMA #1 providing care for him. "I don't want her around me anymore, I don't want her around me, she doesn't take care of me. She did come in and did help me do something after that happened [indicating the incident], I can't stand. No, I'm afraid. I think she was mad at someone and took it out on me." So you do not want QMA #1 to take care of you anymore? "No, she is not very friendly. I like to kid and she is not that type of person." When asked do you think QMA #1 was intentionally mean to you, Resident #143 indicated, "I don't know, she was mean." Did you say anything to her? "Yes, I yelled."</p> <p>On 9/16/14 at 11:35 a.m., interview with RN #3 indicated, when asked if she could tell me about the incident with Resident #143. "I was in the hallway outside of door passing medicine. I heard him</p>				<p>they need to report and the investigation will be done to determine outcome. All allegations will be reported to the ISDH. This training includes all staff working all shifts. 5) By what date the systemic changes will be completed. October 13, 2014</p>		

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	<p>yelling at her [Name of QMA#1]. I really did not see what was going on, but I could hear. So I went in the room and he was upset with the CNA [QMA #1]. He said that she was being rough with him and he was mad. What I heard was that she was going to have to roll him from one side to other to change him. I have never seen her being mean." Do you recall what time this incident happen? "In in the morning with her last bed check around 5 or 6.[a.m.]." After that happened what did you do? "I don't remember filing a complaint cause he calmed down. I remember talking to [Name of the DON] shortly after that." What is the abuse protocol? "You are suppose to notify the nurse on call. I want to say 24 hours, but that's not right, I think immediately. I don't consider that abuse. If any he was abusing her." Can you tell me the different types of abuse? "Verbally, physically, emotionally." Did any of those things happen to him? [Indicating Resident #143] "Not that I know of." Did Resident #143 at any time hit the wall during this incident? "Not that I know of, there was plenty of room for him not to hit the wall."</p> <p>Review of "State Agency Unusual Occurrence Report" dated October 8, 2013 indicated, " Resident #143 is an assist of 2 and full body lift to transfer...</p>						

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	<p>[Name of Resident #143] has reported on 10/4/13 that he felt a [nurse] was rough on 9/28/13. ...Addendum upon investigation it was found the staff member that the resident reported was [Name of QMA #1]. [Name of QMA #1] was changing [Name of Resident #143] in bed before breakfast. [Name of Resident#143] is an assist of 2 and full body lift to transfer. [Name of QMA #1] was rolling [Name of Resident #143] over in bed alone, because [Name of Resident 143] is a large man he is at times difficult to position. A nurse [Name of RN #3] was in the hall outside [Name of Resident #143] room and heard [Name of QMA #1] inform resident of the care that was being done and asked [Name of Resident #143] to assist in rolling over. [Name of RN #3] denied any malicious tone or behavior on [Name of QMA #1] part and [name of resident #143] had no complaints or distress at that time. [Name of QMA #1] denied there being any problems with [Name of Resident #143] at any time. [Name of Resident #143] has asked to withdraw the complaint after voicing the initial concern stating 'there isn't any problems. She's been nice to me since and I don't want anyone to get in trouble].' "</p> <p>On 10/5/13 there was documentation of a phone conversation with the DON and</p>						

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	<p>RN #3 regarding the incident with Resident #143 which took place on 9/28/14. This was 7 days after the incident occurred.</p> <p>On 9/16/14 at 12:50 p.m., interview with the DON indicated, "The incident happened on September 28, of 2013 and [Name of Resident] reported it on 10/4/14. I think his daughter was visiting and she told us." When asked when did RN #3 report it to you? "I talked to her [indicating RN #3] on 10/5/14. We made sure that [Name of QMA #1] was not working while we did our investigation." Did [Name of RN #3] call you? "When on the 28th? No, because he didn't complained or yell out about the QMA [QMA #1] so she [indicating RN #3] didn't talk to me until the 5th when I called her. [Name of Resident #143] is a two person assist with a hoyer. The QMA [indicating QMA #1] may have had trouble maneuvering him by herself." What was the outcome of your investigation? "It was not malicious, it was not abuse and intentional. He never said that he didn't want her to care for him. In fact she has cared for him since the incident." When informed that RN #3 indicated when interviewed "[Name of Resident #143] had yelled that is when she entered the room and Resident #143 said that she was being rough [indicating</p>						

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	<p>QMA #1]. The DON indicated, "She did not tell me that."</p> <p>On 9/10/14 at 11:00 a.m., the Administrator provided policy "Abuse/Elder Abuse Act Policy" revised date March 2004, and indicated that was the policy currently used by the facility. The policy indicated, "...These are different types of abuse: ...Catastrophic reactions-extraordinary reactions by a resident over ordinary stimuli, such as basic care. Response may be weeping, anger, agitation, ... Any complainants of abuse by a resident ... will be immediately addressed by the nurse on duty and a Concern/Suggestion form on behalf of the resident.... The staff will take immediate precautions to assure the resident is protected from any further abusive acts while the report is being investigated, such as staff suspension, separating residents or increased observation. Social service will visit the resident to assess for psychosocial needs. ... While these initial report forms need to be initiated by the staff nurse, the Administrator and Director of Nursing ... should be notified immediately and will begin the report to the State Board of Health, ...if no bodily injury has occurred the report will be sent within 24 hours, ...Abuse... Every resident has the right to be free from mistreatment, ...All</p>						

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	reporting by staff to the RN on call and/or the administrator must occur immediately as the incident has occurred ... the investigation must being immediately, ..."						
F000225 SS=D	<p>3.1-28(a)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property</p>						

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	<p>are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure an occurrence of resident mistreatment was immediately reported to the administrator of the facility or other officials as indicated by the facilities' abuse policy for 1 of 1 residents interviewed for an allegation of mistreatment. (Resident #143) (RN #3, QMA#1)</p> <p>Findings include:</p> <p>Resident #143's clinical record was reviewed on 9/12/14 at 1:43 p.m. Diagnoses included, but were not limited to: anxiety, depression with suicidal ideation, atrial fibrillation (irregular heart</p>	F000225	F225 It is the policy of Garden Villa to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property be reported immediately to the required authorities. 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The QMA in question no longer provides care for Resident #143, though Resident #143 has verbalized he welcomed the interaction and care from QMA#1. A careplan was held with Resident #143 and the POA. Both agree that they feel that Resident #143 is safe in our care and have no concerns	10/13/2014			

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	<p>rhythm) hypertension, insomnia, and osteoarthritis.</p> <p>The current MDS (Minimum Data Set) assessment dated 7/30/14, indicated a BIMS (Brief Interview Mental Status) score was 13. When 8-15 indicated Resident #143 was cognitively intact and interviewable.</p> <p>On 9/12/14 2:49 p.m., interview with the Administrator indicated, "Allegation of abuse came up, [Name of Resident #143], and QMA #1. I can not tell you dates, one morning I walked down the hall, he said, a CNA bumped me into the wall. I immediately called the QMA [Name of QMA #1] she indicated, "The legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating RN #3]. When I asked [Name of Resident #143] if she did it intentionally he said, "She did not intentionally do it ,she apologized to me." When I went back to him he said that he did not feel like the CNA [QMA #1] did it on purpose and it was an accident. I called the daughter and explained to her that he has repeated that again [indicating speaking about the incident with QMA #1]. He said that, 'she put him on the bed.' The nurse that watched said that it wasn't like that. morning care was being provided, he was already in bed."</p>			<p>about his well being beyond his cognitive impairment. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken All residents have the potential to be affected by abuse. Inservice was given regarding abuse and reporting. All facility staff were required to read and sign the training provided. This training specifically details the timeframe requirements for reporting. See attached #1. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur Upon hire, criminal history checks and drug testing are done, dementia and abuse training is completed and at least annually thereafter. All staff have been educated on what abuse looks like and signs and symptoms of staff burnout. The process for shift report has changed to have licensed staff report information about resident change in condition to the CNAs and needed change in interventions in their care. This process will be a more proactive approach versus reactive. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. In addition to our current Quality Assurance</p>			

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	<p>On 9/16/14 at 11:35 a.m., interview with RN #3 indicated, when asked if she could tell me about the incident with Resident #143. "I was in the hallway outside of door passing medicine. I heard him yelling at her [Name of QMA #1]. I really did not see what was going on but I could hear. So I went in the room and he was upset with the CNA [QMA #1]. He said that she was being rough with him and he was mad. What I heard was that she was going to have to roll him from one side to other to change him. I have never seen her being mean." Do you recall what time this incident happen? "In in the morning with her last bed check around 5 or 6.[a.m.]." After that happened what did you do? "I don't remember filing a complaint cause he calmed down. I remember talking to [Name of the DON] shortly after that." What is the abuse protocol? "You are suppose to notify the nurse on call. I want to say 24 hours, but that's not right, I think immediately. I don't consider that abuse. If any he was abusing her." Can you tell me the different types of abuse? "Verbally, physically, emotionally." Did any of those things happen to him [Indicating Resident #143]? "Not that I know of." Did Resident #143 at any time hit the wall during this incident? "Not that I know of, there was plenty of room</p>			<p>program, daily, administrative staff will verify any changes in resident care interventions have been updated on CNA assignment sheets and Care Plans and communicated to floor staff. Monthly this report will be included in the QA program. After 3 months, this process will be reviewed for a scheule change if no concerns found. ADDENDUM: While Garden Villa has a Chain of Command, in this circumstance, we train staff to follow the guidelines set forth in the Elder Abuse Act stating : "Each employee, agent, contractor, manager, owner, or operator of this facility is individually responsible to report the reasonable suspicion of a crime against a resident.." The education was clarified to explain to the staff that suspicion is all they need to report and the investigation will be done to determine outcome. All allegations will be reported to the ISDH. This training includes all staff working all shifts. 5) By what date the systemic changes will be completed. October 13, 2014</p>			

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	<p>for him not to hit the wall."</p> <p>There was no incident report completed on 9/28/13, nor was the Administrator, DON or on call nurse immediately notified. QMA #1 was not sent home upon the allegation from Resident #143, as indicated by the Director of Nursing.</p> <p>Review of "State Agency Unusual Occurrence Report" dated October 8, 2013, provided by the facility, indicated "Resident #143 is an assist of 2 and full body lift to transfer...[Name of Resident #143] has reported on 10/4/13 that he felt a [nurse] was rough on 9/28/13. ...Addendum upon investigation it was found the staff member that the resident reported was [Name of QMA #1]. [Name of QMA #1] was changing [Name of Resident #143] in bed before breakfast. [Name of Resident#143] is an assist of 2 and full body lift to transfer. [Name of QMA #1] was rolling [Name of Resident #143] over in bed alone because [Name of Resident 143] is a large man he is at times difficult to position. A nurse [Name of RN #3] was in the hall outside [Name of Resident #143] room and heard [Name of QMA #1] inform resident of the care that was being done and asked [Name of Resident #143] to assist in rolling over. [Name of RN #3] denied any malicious tone or behavior on [Name</p>						

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	<p>of QMA #1] part and [name of resident #143] had no complaints or distress at that time. [Name of QMA #1] denied there being any problems with [Name of Resident #143] at any time. [Name of Resident #143] has asked to withdraw the complaint after voicing the initial concern, stating there isn't any problems. She's been nice to me since and I don't want anyone to get in trouble."</p> <p>On 10/5/13 there was documentation of a phone conversation with the DON and RN #3 regarding the incident with Resident #143 which took place on 9/28/14. This was 7 days after the incident occurred.</p> <p>On 9/16/14 at 12:50 p.m., interview with the DON indicated, "The incident happened on September 28, of 2013, and [Name of Resident #143] reported it October 04, 2013. I think his daughter was visiting and she told us." When asked when did RN #3 report it to you? "I talked to her [indicating RN#3] on October 05, 2013. We made sure that [Name of QMA#1] was not working while we did our investigation." Did [Name of RN #3] call you? "When on the 28th? No, because he didn't complained or yell out about the QMA [QMA #1] so she [indicating RN #3]</p>						

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	<p>didn't talk to me until the 5th when I called her. [Name of Resident #143] is a two person assist with a hoyer. The QMA [QMA #1] may have had trouble maneuvering him by herself." What was the outcome of your investigation? "It was not malicious, it was not abuse and intentional. He never said that he didn't want her to care for him. In fact she has cared for him since the incident." When informed that RN #3 indicated when interviewed "[Name of Resident #143] had yelled, that is when she entered the room and Resident #143 said that she was being rough [indicating QMA #1]. The DON indicated, "She did not tell me that."</p> <p>On 9/10/14 at 11:00 a.m., the Administrator provided policy "Abuse/Elder Abuse Act Policy" revised date March 2004, and indicated that was the policy currently used by the facility. The policy indicated, "...These are different types of abuse: ... Catastrophic reactions-extraordinary reactions by a resident over ordinary stimuli, such as basic care. Response may be weeping, anger, agitation, ... Any complainants of abuse by a resident ... will be immediately addressed by the nurse on duty and a Concern/Suggestion form on behalf of the resident... The staff will take immediate precautions to assure the</p>						

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	<p>resident is protected from any further abusive acts while the report is being investigated, such as staff suspension, separating residents or increased observation. Social service will visit the resident to assess for psychosocial needs. ... While these initial report forms need to be initiated by the staff nurse, the Administrator and Director of Nursing ... should be notified immediately and will begin the report to the State Board of Health, ...if no bodily injury has occurred the report will be sent within 24 hours, ...Abuse... Every resident has the right to be free from mistreatment, ...All reporting by staff to the RN on call and/or the administrator must occur immediately as the incident has occurred ... the investigation must being immediately, ..."</p> <p>3.1-28(b)</p>						
F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of</p>						

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	<p>residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure implementation of abuse policy and procedure of an occurrence of mistreatment was immediately reported to the administrator of the facility or other officials as indicated by the abuse policy and procedure for 1 of 1 residents reviewed for an allegation of mistreatment. (Resident #143) (RN #3, QMA#1)</p> <p>Findings include:</p> <p>Resident #143's clinical record was reviewed on 9/12/14 at 1:43 p.m.</p> <p>Diagnoses included, but were not limited to: anxiety, depression with suicidal ideation, atrial fibrillation (irregular heart rhythm) hypertension, insomnia, and osteoarthritis.</p> <p>The current MDS (Minimum Data Set) assessment dated 7/30/14, indicated a BIMS (Brief Interview Mental Status) score was 13. When 8-15 indicated Resident #143 was cognitively intact and interviewable.</p> <p>On 9/12/14 2:49 p.m., interview with the Administrator indicated, "Allegation of abuse came up, [Name of Resident</p>	F000226	<p>F226 It is the policy of Garden Villa to ensure that the facility implements the procedures outlined in the Abuse Policy and immediately informs the Administrator or other official. Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements. 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The QMA in question no longer provides care for Resident #143, though Resident #143 has verbalized he welcomed the interaction and care from QMA#1. A careplan was held with Resident #143 and the POA. Both agree that they feel that Resident #143 is safe in our care and have no concerns about his well being beyond his cognitive impairment. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken All residents have the potential to be affected by abuse. Inservice was given regarding abuse and reporting. All facility staff were required to read and sign the training provided. This training specifically details the timeframe requirements for reporting. See attached #1. 3) What measures will be put into place or what</p>		10/13/2014		

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	<p>#143], and QMA #1. I can not tell you dates, one morning I walked down the hall, he said, a CNA bumped me into the wall. I immediately called the QMA [Name of QMA #1] she indicated, "The legs hit the wall, and the resident was mad about it. The nurse saw it [Indicating RN #3]. When I asked [Name of Resident #143] if she did it intentionally he said, "She did not intentionally do it ,she apologized to me." When I went back to him he said that he did not feel like the CNA [QMA #1] did it on purpose and it was an accident. I called the daughter and explained to her that he has repeated that again [indicating speaking about the incident with QMA #1]. He said that, 'she put him on the bed.' The nurse that watched said that it wasn't like that. morning care was being provided, he was already in bed."</p> <p>On 9/16/14 at 11:35 a.m., interview with RN #3 indicated, when asked if she could tell me about the incident with Resident #143. "I was in the hallway outside of door passing medicine. I heard him yelling at her [Name of QMA #1]. I really did not see what was going on but I could hear. So I went in the room and he was upset with the CNA [QMA #1]. He said that she was being rough with him and he was mad. What I heard was that she was going to have to roll him from</p>		<p>systemic changes will be made to ensure that the deficient practice does not recur Upon hire, criminal history checks and drug testing are done, dementia and abuse training is completed and at least annually thereafter. All staff have been educated on what abuse looks like and signs and symptoms of staff burnout. The process for shift report has changed to have licensed staff report information about resident change in condition to the CNAs and needed change in interventions in their care. This process will be a more proactive approach versus reactive. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. In addition to our current Quality Assurance program, daily, administrative staff will verify any changes in resident care interventions have been updated on CNA assignment sheets and Care Plans and communicated to floor staff. Monthly this report will be included in the QA program. After 3 months, this process will be reviewed for a scheule change if no concerns found. ADDENDUM: While Garden Villa has a Chain of Command, in this circumstance, we train staff to follow the guidelines set forth in the Elder Abuse Act stating : "Each employee, agent, contractor,</p>				

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	<p>one side to other to change him. I have never seen her being mean." Do you recall what time this incident happen? "In in the morning with her last bed check around 5 or 6.[a.m.]." After that happened what did you do? "I don't remember filing a complaint cause he calmed down. I remember talking to [Name of the DON] shortly after that." What is the abuse protocol? "You are suppose to notify the nurse on call. I want to say 24 hours, but that's not right, I think immediately. I don't consider that abuse. If any he was abusing her." Can you tell me the different types of abuse? "Verbally, physically, emotionally." Did any of those things happen to him [Indicating Resident #143]? "Not that I know of." Did Resident #143 at any time hit the wall during this incident? "Not that I know of, there was plenty of room for him not to hit the wall."</p> <p>There was no incident report completed on 9/28/13, nor was the Administrator, DON or on call nurse immediately notified. QMA #1 was not sent home upon the allegation from Resident #143, as indicated by the Director of Nursing.</p> <p>Review of "State Agency Unusual Occurrence Report" dated October 8, 2013, provided by the facility, indicated "Resident #143 is an assist of 2 and full</p>		<p>manager, owner, or operator of this facility is individually responsible to report the reasonable suspicion of a crime against a resident.." The education was clarified to explain to the staff that suspicion is all they need to report and the investigation will be done to determine outcome. All allegations will be reported to the ISDH. This training includes all staff working all shifts. 5) By what date the systemic changes will be completed. October 13, 2014</p>				

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	<p>body lift to transfer...[Name of Resident #143] has reported on 10/4/13 that he felt a [nurse] was rough on 9/28/13. ...Addendum upon investigation it was found the staff member that the resident reported was [Name of QMA #1]. [Name of QMA #1] was changing [Name of Resident #143] in bed before breakfast. [Name of Resident#143] is an assist of 2 and full body lift to transfer. [Name of QMA #1] was rolling [Name of Resident #143] over in bed alone because [Name of Resident 143] is a large man he is at times difficult to position. A nurse [Name of RN #3] was in the hall outside [Name of Resident #143] room and heard [Name of QMA #1] inform resident of the care that was being done and asked [Name of Resident #143] to assist in rolling over. [Name of RN #3] denied any malicious tone or behavior on [Name of QMA #1] part and [name of resident #143] had no complaints or distress at that time. [Name of QMA #1] denied there being any problems with [Name of Resident #143] at any time. [Name of Resident #143] has asked to withdraw the complaint after voicing the initial concern, stating there isn't any problems. She's been nice to me since and I don't want anyone to get in trouble."</p> <p>On 10/5/13 there was documentation of a phone conversation with the DON and</p>						

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	<p>RN #3 regarding the incident with Resident #143 which took place on 9/28/14.</p> <p>This was 7 days after the incident occurred.</p> <p>On 9/16/14 at 12:50 p.m., interview with the DON indicated, "The incident happened on September 28, of 2013, and [Name of Resident #143] reported it October 04, 2013. I think his daughter was visiting and she told us." When asked when did RN #3 report it to you? "I talked to her [indicating RN#3] on October 05, 2013. We made sure that [Name of QMA#1] was not working while we did our investigation." Did [Name of RN #3] call you? "When on the 28th? No, because he didn't complained or yell out about the QMA [QMA #1] so she [indicating RN #3] didn't talk to me until the 5th when I called her. [Name of Resident #143] is a two person assist with a hoyer. The QMA [QMA #1] may have had trouble maneuvering him by herself." What was the outcome of your investigation? "It was not malicious, it was not abuse and intentional. He never said that he didn't want her to care for him. In fact she has cared for him since the incident." When informed that RN #3 indicated when interviewed "[Name of Resident #143] had yelled, that is when she entered the</p>						

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	<p>room and Resident #143 said that she was being rough [indicating QMA #1]. The DON indicated, "She did not tell me that."</p> <p>On 9/10/14 at 11:00 a.m., the Administrator provided policy "Abuse/Elder Abuse Act Policy" revised date March 2004, and indicated that was the policy currently used by the facility. The policy indicated, "...These are different types of abuse: ... Catastrophic reactions-extraordinary reactions by a resident over ordinary stimuli, such as basic care. Response may be weeping, anger, agitation, ... Any complainants of abuse by a resident ... will be immediately addressed by the nurse on duty and a Concern/Suggestion form on behalf of the resident... The staff will take immediate precautions to assure the resident is protected from any further abusive acts while the report is being investigated, such as staff suspension, separating residents or increased observation. Social service will visit the resident to assess for psychosocial needs. ... While these initial report forms need to be initiated by the staff nurse, the Administrator and Director of Nursing ... should be notified immediately and will begin the report to the State Board of Health, ...if no bodily injury has occurred the report will be sent within 24 hours,</p>						

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F000323 SS=D	<p>...Abuse... Every resident has the right to be free from mistreatment, ...All reporting by staff to the RN on call and/or the administrator must occur immediately as the incident has occurred ... the investigation must being immediately, ..."</p> <p>3.1-28(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents with history of falls wore the recommended non skid socks at all times while in bed for 1 of 5 residents in a sample of 5 who met the criteria for review of accidents. (Resident #115) (CNA #1)</p> <p>Findings include:</p> <p>Resident #115's clinical records were reviewed on 9/12/14 at 12:20 p.m. Diagnoses include but were not limited</p>	F000323	F 323 It is the policy of Garden Villa to ensure that the resident environment remains as free from accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements. 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #115 has the intervention for non-skid socks while in bed. The non-skid socks	10/13/2014			

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	<p>to: hip fracture, anxiety, history of falls, hyperlipidemia, difficulty walking, abnormality of gait and hyponatremia.</p> <p>The current MDS (Minimum Data Set) assessment dated 6/30/14, indicated a BIMS (Brief Interview Mental Status) was 13, which indicated cognitively intact and interviewable. The MDS indicated Resident #115 needed extensive assistance of 1 staff member for bed mobility, extensive assistance of 1 staff for transfer, limited assistance of 2 staff members for walk in room.</p> <p>Review of nursing notes dated 8/21/14 indicated , At 3:50 p.m. Resident was heard calling out [Help me] was found laying on floor c [with] head resting on Mattress. She stated she was sitting on edge of bed, waiting to go to the bathroom & [and] she slid to the floor. ..."</p> <p>Review Nursing note dated 8/25/14 indicated, " ...Order Rec'd [received] Non skid socks to be worn while in bed. ..."</p> <p>Physician's order dated 8/25/14 indicated, "Non-skid socks to be worn while in bed."</p> <p>Careplan dated 10/31/13, for "Functional Maintenance Program: Restorative</p>		<p>were put on resident and no incident or injury occurred. This intervention remains in place and was and is on the assignment sheet. CNA #1 was re-educated on following the assignment sheet for any and all resident interventions. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this deficient practice. All nursing staff will be re-educated on the the importance of following the Care Plan/Assignment sheets for each individual resident and their interventions. See Attached #2.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Ten random staff will be audited weekly to verify staff compliance with resident specific interventions as outlined on their assignment sheets. See attached. ADDENDUM: This random audit will include all three shifts 7/days a week. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. These audits will be presented in Quality Assurance for 3 months for compliance and if no concerns will be reviewed for scheduled change. 5) By what date the</p>				

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	<p>ambulation: Potential for decrease in ambulation ability due to dx [diagnosis]: HTN (hypertension), depression, & anxiety. ... Resident will ambulate 75 feet using front wheel walker and SBA [Stand by Assist] x 7 days a week... Ensure proper footwear is worn. ... PT [Physical Therapy] screen at least quarterly. ..."</p> <p>Care plan dated 8/22/14, for "Risk for falls characterized by history of falls/injury, multiple risk factors related to: ...impaired balance, poor coordination, unsteady gait, non compliance with mobility aide use, ... history of falls, requires assist to transfer. ...Interventions: ... Assist resident with transfers with assist of :1 staff, call light within reach and answer promptly, ... Reinforce need to call for assistance, low bed, ... Not to be left alone in room while up, ..."</p> <p>On 9/15/14 at 1:10 p.m., Resident #115 was observed lying in the bed with feet hanging over the side without non skid socks on. When asked where were the non skid socks? Resident #115 indicated, " Its not on my feet."</p> <p>On 9/15/14 at 1:20 p.m., CNA #1 indicated when asked if Resident #115 should have non skid socks on while in bed. "No, no one ever told me that."</p>		systemic changes will be completed. October 13, 2014				

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	<p>When asked if she had an assignment sheet for Resident #115 which would say what care Resident #115 would need, CNA #1 indicated, "I don't think the assignment sheet would have that on it. I don't think any of the other CNA's know that either [indicating the non skid socks]." CNA #1 asked Resident #115 where her socks were and Resident #115 indicated, "In the drawer where you put them." Observed CNA #1 to retrieve the non skid socks out of the top dresser drawer and place on Resident #115's feet. CNA #1 indicated to Resident #115 "You told me to put them there."</p> <p>On 9/10/14 at 2:20 p.m., interview with LPN #1 indicated Resident #115 fell on 8/22/14. She [Name of Resident #115] slide off the edge of bed. When asked what interventions were put in place after fall, LPN #1 indicated, "We have her wear non-skid socks while in bed and she's was already on low bed."</p> <p>On 9/15/14 at 10:32 a.m., interview with the MDS (Minimum Data Set) coordinator indicated, when asked how did Resident #115 fall, "She was trying to go to the bathroom and feet slid out from under her. She tried to get herself up and her feet slid." When asked if Resident #115 knew how to use the call light, the MDS coordinator indicated, "She does</p>						

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	<p>know how to use the call light and usually does but not always." When asked if anyone saw Resident #115 fall, MDS coordinator indicated, "It was not a witness fall. They heard her yelling. She does have to use the bathroom frequently."</p> <p>On 9/15/14 at 1:10 p.m., interview with Resident #115 indicated, when asked why were you trying to get out of bed on the day you fell? "I was sitting on the side of the bed hollering for someone to help me to the bathroom. No one came and both my feet just slid right from under me." When asked why didn't she use the call light, Resident #115 indicated, "I couldn't reach it." When asked if the call light was in reach would she have used it? Resident #115 indicated, "Yes."</p> <p>Fall Risk Assessment dated 8/25/14 indicated "...History of Falls [past 3 months] ... 1-2 Falls in past 3 months #2, ... Ambulation/Elimination Status... Chair Bound-requires assist assist w/toileting [with] #2, ... Gait/Balance ... Requires use of assistive devices ... #1, ... Total Score above 10 represent HIGH RISK 11 ... Resident Education: Call Light Use, ... Low Bed, ... 8/25/14: Non Skid Socks to be worn while in bed, ..."</p>						

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F000371 SS=E	<p>CNA #1 provided "Station 3 C.N.A. Assignment Sheet" dated 9/15/2014, and indicated that was the current resident care assignment sheet. The sheet indicated, "... [Name of Resident #115] ... sock to be worn while in bed, ..."</p> <p>On 9/16/14 at 9:47 a.m., the DON provided form labeled "Continuing Care Incorporated, CNA Orientation Checklist" undated, The form indicated "Item of instruction, Returned Demonstration, Policy & Procedure Reviewed, No Hands-on, ... Use of careplans/CNA Assignment sheet ..."</p> <p>3.1-45(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure cold food were stored at the proper temperature indicated by the facility policy and 410 IAC 7-24 Retail Food Establishment Sanitation Requirements in that cold food temperatures were</p>	F000371	F371 It is the policy of Garden Villa to ensure that cold food is stored at the proper temperature and to follow proper sanitation and food handling practices to prevent the outbreak of food bourne illness. 1) What corrective action(s) will be accomplished for those residents	10/13/2014			

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	<p>measured at 42 degrees Fahrenheit.</p> <p>Findings include:</p> <p>On 9/12/14 at 10:30 a.m., interview with the kitchen Night Shift Supervisor indicated, 181 residents were served from the kitchen. The Night Shift Supervisor indicated there were approximately 100 residents who received puree prepared foods, 25 residents received mechanical soft prepared foods and 56 regular diets.</p> <p>On 9/12/14 at 11:25 a.m., observed Cook #1 recording temperatures on cold food items which were observed sitting out in the kitchen for 1 hour. The temperature of the cottage cheese which was in a bowl on a cart was tempted at 49.8 degrees. There was yogurt in a metal pan with temperature of 42 degrees Fahrenheit. When asked what the temperature should be on cold items, Cook #1 indicated, "Thirty-two to forty-one degrees." The Dietary Aide (DA) #1 was told by the Chef to throw all of the cottage cheese cups that were on the tray and all the yogurt which were in the pan out. D.A. #1 was observed at that time to remove the tray of cottage cheese and pan of yogurt.</p> <p>On 9/12/14 at 12:15 p.m., the Chef provided documentation labeled "Food</p>		<p>found to have been affected by the deficient practice.</p> <p>Immediately the cold food items found beyond the temperature requirement were disposed of. No other food items were found outside the food temperature requirement. No residents were harmed or served items outside the temperature guideline. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by time and temperature abuse (TCS). The dietary staff was inserviced regarding temperature, food line set-ups and daily auditing. A change in the way the cold items are being held was implemented and timing of items that are out during service. Potentially hazardous foods or time temperature control for safety food held in the danger zone for more than 4 hours may cause a food borne illness outbreak if consumed. Any and all TCS foods must be discarded prior to the 4th hour. Based on this requirement the food items discarded were not within the food borne illness requirement range. The kitchen is now writing down the time items are taken out of the refrigerator to ensure we meet the time and temperature requirements. 3) What measures will be put into place or</p>				

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	<p>Safety Information" revised date October 2011. The documentation indicated, "... [Danger Zone] [40 degree F-140 degree F] Fahrenheit ... Leaving food out too long at room temperature can cause bacteria [such as Staphylococcus aureus. Salmonella Enteritis, Escherichia coli ... to grow to dangerous levels that can cause illness. Bacteria grow most rapidly in the range of temperatures between 40 degree F and 140 degree F, doubling in number in as little as 20 minutes. ... Keep cold food cold--at or below 40 degree F. Place food in containers on ice."</p> <p>On 9/12/14 at 12:15 p.m., the Chef provided policy labeled "FOOD SAFETY FOOD STORAGE GUIDELINES" undated and indicated that was the one currently used by the facility. The policy indicated, " ... All foods are stored in a safe manner. ... Procedure ... I. Danger zone: temperature range [40 to 140 degrees] in which bacteria and other microbes grow rapidly. ..."</p> <p>On 9/17/14 at 1:03 p.m., review of the 410 IAC 7-24-187 dated November 13, 2004, indicated "Potentially hazardous food;hot and cold holding, ...[a] Except during preparation, cooking, or cooling, ...potentially hazardous food shall be</p>		<p>what systemic changes will be made to ensure that the deficient practice does not recur. All times for all TCS foods will be documented/logged when removed from the refrigerator. This Time In/Out log will document time items were removed from refrigerator and will ensure that items prior to the 4th hour are discarded. See attached #3. ADDENDUM: This will include all three meals 7/days a week. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Daily the log will be reviewed for compliance by the Chef or his designee. These logs will be presented monthly in Quality Assurance for 3 months and then reviewed for a schdeule change if no concerns. 5) By what date the systemic changes will be completed. October 13, 2014</p>				

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F000431 SS=D	<p>maintained as follows: ...[2] At a temperature specified in the following: [A]At forty-one [41] degrees Fahrenheit or less. ..."</p> <p>3.1-21 (i)(2)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked,</p>						

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	<p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure expired medications were disposed of as the facility policy indicated and a medication was stored at the proper temperature in that promethazine suppositories were not refrigerated as the pharmacy indicated for 3 of 12 medications carts (Station 3 South Middle Cart, Station 1 North medication cart, Station 3 North #2 medication cart) on 3 of 6 units reviewed for medication storage. (Resident #9, Resident #245, Resident #246)</p> <p>Findings include:</p> <p>On 9/12/2014 at 12:30 p.m., an observation of Station 3 South's middle medication cart included the following: one vial of Resident #245's nitroglycerine (used for moderate to severe acute angina/rapid onset of chest pain) 0.4 mg (milligram) vial had been dispensed from the pharmacy on 12/23/2011, the manufacturer's expiration date was 8/2014. At that time, an interview with</p>	F000431	<p>F431 It is the policy of Garden Villa to ensure that expired medications are disposed of and stored at the proper temperature.</p> <p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>No residents were affected by medication cited as no medication expired had been administered. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this deficient practice. Medication carts have been and are being monitored for medication compliance. Any medication found will be disposed of and documented per facility policy. All promethazine suppositories labeled refrigerate are in the refrigerator, despite that the medication is stable per the manufacturer guideline not refergerated. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>	10/13/2014			

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	<p>RN #1 indicated the nitroglycerine was expired on 8/2014, and would need to be disposed of and removed it from the medication cart.</p> <p>On 9/12/2014 at 12:35 p.m., an observation of Station 3 South's middle medication cart included the following: Resident #246's ondanestron (used for nausea and vomiting) 4 mg dispensed from the pharmacy on 8/23/2013, had a expiration date of 8/23/2014. At that time, an interview with RN #1 indicated the ondanestron was expired and would need to be disposed of and removed it from the medication cart.</p> <p>On 9/12/2014 at 1:00 p.m., an observation of Station 1's North medication cart included the following: an Advair Diskus (respiratory inhaler used for maintenance therapy for airflow obstruction in patient with chronic obstructive pulmonary disease/maintenance of asthma) did not have a pharmacy or patient label, the diskus had a manufacturers expiration date of 4/2014. At that time, the Station 1 Unit Manager and RN #2 indicated the Advair Diskus did not have a pharmacy nor patient label was expired and would be disposed of.</p> <p>An observation on 9/12/2014 at 1:15</p>		<p>practice does not recur. All licensed staff have been re-educated to verify expiration dates before administering medication and medication carts are being audited by nursing administration weekly for expired meds. and proper storage. This education has also been added to the new nurse orientation for new employees. See attached #4.</p> <p>4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Medication carts are being audited by nursing administration weekly for expired meds. and proper storage. These audits will be presented in Quality Assurance for 3 months and then reviewed for schedule change if no concerns. 5) By what date the systemic changes will be completed. October 13, 2014</p>				

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	<p>p.m., of Station 3's North Medication cart included the following: Resident #9's promethazine 25 mg rectal suppositories (used for nausea) dispensed from the pharmacy on 8/18/2014. The 6 promethazine suppositories were in the top drawer of the medication cart at room temperature. The label from the pharmacy indicated refrigerate. At that time, the Unit Manager for Station 3 North indicated the suppositories should be refrigerated and would be disposed of.</p> <p>On 9/16/2014 at 12:49 p.m., an interview with the pharmacist indicated the pharmacy recommends that promethazine suppositories should be refrigerated for ease of insertion rectally.</p> <p>On 9/15/2014 at 9:03 a.m., the Director of Nursing provided the Administering Oral Medications Protocol, dated September 2003, and indicated the policy was the one currently used by the facility. The policy indicated: "...Steps in the Procedure...7. Check the expiration date on the medication. Return any expired medications to the pharmacy...."</p> <p>On 9/16/2014 at 1:00 p.m., the Director of Nursing provided the Preparation and General Guidelines policy, dated 2006, and indicated the policy was the one</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	currently being used by the facility. The policy indicated: " ...F. Medication in multidose vials may be used (until the manufacturer's expiration date...)." <p>3.1-25(o)</p>						